Assassination Records Review Board
Final Determination Notification

AGENCY : HSCA
RECORD NUMBER : 180-10068-10324
RECORD SERIES : STAFF PAYROLL RECORDS
AGENCY FILE NUMBER :

December 8, 1995

Status of Document: Postponed in Part

Number of releases of previously postponed information: 8
Reason for Board Action: The Review Board's decision was premised on several factors including: (a) the significant historical interest in the document in question; (b) the absence of evidence that the release of the information would cause harm to the United States or to any individual.

Number of Postponements: 4

Postponements: All the postponements in this document represent Social Security numbers.

Reason for Board Action: The text is redacted because the public disclosure of the redaction could reasonably be expected to constitute an unwarranted invasion of personal privacy, and that invasion of privacy would be so substantial that it outweighs the public interest.

Substitute Language: SSN

Date of Next Review: 2017

Board Review Completed: 10/24/95

JFK ASSASSINATION SYSTEM

IDENTIFICATION FORM

AGENCY INFORMATION

AGENCY : HSCA
RECORD NUMBER : 180-10068-10324

RECORDS SERIES :
STAFF PAYROLL RECORDS

AGENCY FILE NUMBER :

DOCUMENT INFORMATION

ORIGINATOR : HSCA
FROM :
TO :

TITLE :

DATE : 12/29/77
PAGES : 8

SUBJECTS :
HSCA, ADMINISTRATION
COLLINS, WENDY S.

DOCUMENT TYPE : PRINTED FORM
CLASSIFICATION : U
RESTRICTIONS : 3
CURRENT STATUS : P
DATE OF LAST REVIEW : 07/07/93

OPENING CRITERIA :

COMMENTS :
Box #:1.

[R] - ITEM IS RESTRICTED

(202) 225-4624

Select Committee on Assassinations
U.S. House of Representatives
3369 HOUSE OFFICE BUILDING, ANNEX 2
WASHINGTON, D.C. 20515

December 5, 1978

The Honorable Frank Thompson, Jr.
Chairman
Committee on House Administration
U. S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

Effective December 1, 1978, the official duty station of Ms. Wendy Collins has been changed from Washington, D. C. to Pittsford, Vermont. This change will remain in effect through the balance of the 95th Congress.

Sincerely,

LOUIS STOKES
Chairman

LS:th

PAYROLL AUTHORIZATION FORM

(Please Use Typewriter or Ballpoint Pen)

U.S. HOUSE OF REPRESENTATIVES
Washington, D.C. 20515

(Any erasures, corrections, or changes on this form must be initialed by the authorizing official.)

To the Clerk of the House of Representatives:

I hereby authorize the following payroll action:

Employee Name (First-Middle-Last)	Effective Date
Wendy S. Collins	December 20, 1978
Employee Social Security Number	**Type of Action**
024-44-5163	☐ Appointment ☐ Salary Adjustment ☐ Title Change ☒ Termination (At close of business on effective date) ☐ Leave without pay (Beginning with effective date above and ending close of business_____________________) Specify Date
Employing Office or Committee/Subcommittee	
Assassinations	

(If type of action is an Appointment, Salary Adjustment, or Title Change, complete appropriate information below.)

Position Title	Gross Annual Salary*

* If employee is a civil service annuitant (includes U.S. House of Representatives), the gross annual salary shown should include the annuity received by the employee plus the salary received from the employing office.

(If Committee Employee, complete appropriate item below.)

1. ☐ Standing Committee: Staff—☐ Clerical or ☐ Professional.
2. ☒ Special (Investigative staff of Standing Committee) or Select Committee: Authority—H. Res. [illegible] of [illegible] Congress.
3. ☐ Joint Committee.

(If Employee of an Officer of the House, complete item below.)

Position Number__________ If applicable, Level______ Step______

I certify that this authorization is not in violation of 5 U.S.C. 3110(b), prohibiting the employment of relatives.

Date December 11, 1978, 19____

____
(Signature of Authorizing Official)

____
(If appropriate, signature of Subcommittee Chairman or Ranking Minority Member)

LOUIS STOKES
(Type or print name of Authorizing Official)

____
(Type or print name and title of above official)

Chairman
(Title—If Member, District and State)

All appointments and salary adjustments for employees under the House Classification Act and for Committee employees, except those of the Committee on Appropriations, the Committee on the Budget, and the Joint Committees, must be approved by the Committee on House Administration.

APPROVED:____________________
Chairman, Committee on House Administration

Office of Finance use only:	
Office Code________	ID ________
	Benefits ________
Monthly Annuity $______.00 as of ________	Payroll ________

(Revised: August 1 1977)

Copy for Initiating Office or Committee

PAYROLL AUTHORIZATION FORM

(Please Use Typewriter or Ballpoint Pen)

U.S. HOUSE OF REPRESENTATIVES
Washington, D.C. 20515

(Any erasures, corrections, or changes on this form must be initialed by the authorizing official.)

To the Clerk of the House of Representatives:

I hereby authorize the following payroll action:

Employee Name (First-Middle-Last)	**Effective Date**
Wendy S. Collins	December 29, 1977
Employee Social Security Number	**Type of Action**
024-44-5163	☒ Appointment ☐ Salary Adjustment ☐ Title Change ☐ Termination (At close of business on effective date) ☐ Leave without pay (Beginning with effective date above and ending close of business ______________) Specify Date
Employing Office or Committee/Subcommittee	
Assassinations	

(If type of action is an Appointment, Salary Adjustment, or Title Change, complete appropriate information below.)

Position Title	**Gross Annual Salary***
Research Attorney	$18,000

* If employee is a civil service annuitant (includes U.S. House of Representatives), the gross annual salary shown should include the annuity received by the employee plus the salary received from the employing office.

(If Committee Employee, complete appropriate item below.)

1. ☐ Standing Committee: Staff—☐ Clerical or ☐ Professional.
2. ☒ Special (Investigative staff of Standing Committee) or Select Committee: Authority—H. Res. 465 of 95th Congress.
3. ☐ Joint Committee.

(If Employee of an Officer of the House, complete item below.)

Position Number______________ If applicable, Level________ Step________

I certify that this authorization is not in violation of 5 U.S.C. 3110(b), prohibiting the employment of relatives.

Date December 29, 19 77

(Signature of Authorizing Official)

____
(If appropriate, signature of Subcommittee Chairman or Ranking Minority Member)

Louis Stokes
(Type or print name of Authorizing Official)

____
(Type or print name and title of above official)

Chairman
(Title - If Member, District and State)

All appointments and salary adjustments for employees under the House Classification Act and for Committee employees, except those of the Committee on Appropriations, the Committee on the Budget, and the Joint Committees, must be approved by the Committee on House Administration.

APPROVED: ______________________________
Chairman, Committee on House Administration

Office of Finance use only:	ID ______________
Office Code__________	Benefits ______________
Monthly Annuity $__________.00 as of ______________	Payroll ______________

(Revised: August 1 1977)

Copy for Initiating Office or Committee

☆ U.S. GOVERNMENT PRINTING OFFICE: 1976—599-393 1336

If typewriter is not available, bear down with ball-point pen to make legible copies.

HEALTH BENEFITS REGISTRATION FORM

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

(Read instructions on back of page 3.)

New Carrier's Control No. 22933820

TO EMPLOYING OFFICE: SHOW OLD CARRIER'S CONTROL NUMBER ONLY IF ELECTION IS TO CANCEL ENROLLMENT OR TO CHANGE OPTIONS OR TYPE OF ENROLLMENT IN THE SAME PLAN.

Old Carrier's Control No.

PART A — ALL WHO REGISTER MUST FILL IN THIS PART.

1. NAME (LAST) (FIRST) (MIDDLE INITIAL): Collins Wendy S
2. DATE OF BIRTH (Use numbers): MONTH 03 DAY 22 YEAR 53
3. ARE YOU NOW MARRIED? Yes [1] No [2] ✓
4. YOUR MAILING ADDRESS (NUMBER AND STREET): 1630 Hobart St, N.W.
(CITY) (STATE) (ZIP CODE): WASHINGTON D.C. 20009
5. SOCIAL SECURITY ACCOUNT NUMBER: 024-44-5163
6. SEX: MALE [1] FEMALE [2] ✓

IMPORTANT

IT IS ILLEGAL FOR AN EMPLOYEE OR A MEMBER OF HIS FAMILY TO BE COVERED UNDER MORE THAN ONE ENROLLMENT. IF YOU ARE ALREADY COVERED THROUGH THE FAMILY ENROLLMENT OF ANOTHER FEDERAL OR DISTRICT OF COLUMBIA EMPLOYEE OR ANNUITANT YOU MUST REGISTER NOT TO ENROLL OR THE OTHER ENROLLMENT MUST BE CANCELED OR CHANGED TO SELF ONLY. SIMILARLY, IF A FAMILY MEMBER LISTED BY YOU IN PART B IS COVERED THROUGH HIS (OR HER) OWN ENROLLMENT, YOU CANNOT ELECT A FAMILY ENROLLMENT UNLESS THE FAMILY MEMBER CANCELS HIS (OR HER) ENROLLMENT. ALSO SEE BACK OF PAGES 2 AND 3.

PART B — FILL IN THIS PART IF YOU WISH TO ENROLL OR CHANGE YOUR ENROLLMENT IN A HEALTH BENEFITS PLAN.

If enrollment is for Self Only, answer item 1. If enrollment is for Self and Family, also answer item 2.

IF YOU ARE CHANGING YOUR ENROLLMENT ALSO FILL IN PART D.

1. I elect to enroll in a health benefits plan as shown below. I authorize deductions from my salary, compensation, or annuity to cover my share of the cost of the enrollment. (Copy the information requested below from back page of brochure of the plan you select.)

NAME OF PLAN	OPTION (HIGH OR LOW)	ENROLLMENT CODE NUMBER
Blue Cross/Blue Shield Service Benefit Plan	HIGH	1 0 1

2. In space below list all eligible family members without exception: List your wife or husband first, then your unmarried children under age 22, including (a) legally adopted children and (b) stepchildren, foster children, and illegitimate children who live with you in a regular parent-child relationship. Include also any unmarried child over 22 who became disabled before age 22 and who, because of the disability, is incapable of self-support. (Attach a doctor's certificate for a disabled child age 22 or over, if one is not already on file.) **DO NOT LIST PARENTS OR OTHERS WHO ARE NOT ELIGIBLE FAMILY MEMBERS. THEY WILL NOT RECEIVE BENEFITS, EVEN IF THEY ARE DEPENDENT ON YOU AND ARE LISTED.**

NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)	NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)
Wife or Husband	1		6
	2		7
	3		8
	4		9
	5		10

PART C — FILL IN THIS PART IF YOU WISH NOT TO ENROLL OR IF YOU WISH TO CANCEL YOUR ENROLLMENT.

PLACE AN "X" IN ITEM 1 OR 2 WHICHEVER APPLIES:

1. I ELECT NOT TO ENROLL IN A PLAN UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM. [ ]
2. I ELECT TO CANCEL MY PRESENT ENROLLMENT UNDER THE CODE NUMBER SHOWN BELOW. [ ]

Present Enrollment Code Number

If you elect to cancel be sure to read "Cancellation of Enrollment" on back of page 3.

PART D — FILL IN THIS PART, AS WELL AS PART B, TO CHANGE YOUR REGISTRATION.

ANSWER ITEMS 1, 2, AND 3 TO SHOW ENROLLMENT CODE BEING CHANGED AND ELIGIBILITY FOR CHANGE.

1. ENROLLMENT CODE NUMBER OF PRESENT PLAN
2. NUMBER OF EVENT WHICH PERMITS CHANGE. (See table on back of page 2 for proper number.)
3. DATE OF EVENT WHICH PERMITS CHANGE. MONTH DAY YEAR

PART E — ALL WHO REGISTER MUST FILL IN THIS PART.

Wendy S Collins (YOUR SIGNATURE. DO NOT PRINT) Aug 5, 1978 (DATE)

WARNING.—Any intentional false statement in this application or wilful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

PART F — TO BE COMPLETED BY AGENCY

1. NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYING OFFICE:
U.S. House of Representatives
Office of Finance, Washington, D.C. 20515

(SIGNATURE OF AUTHORIZED AGENCY OFFICIAL)

2. DATE RECEIVED IN EMPLOYING OFFICE
3. EFFECTIVE DATE OF ELECTION
4. PAYROLL OFFICE NO. 00004832
5. SF 2811 REPORT NO.

REMARKS — FOR USE ONLY BY AGENCY.

Standard Form No. 2809
U.S. Civil Service Commission
FPM Supplement 890-1
November 1972

If typewriter is not available, bear down with ball-point pen to make legible copies.

HEALTH BENEFITS REGISTRATION FORM

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

(Read instructions on back of page 3.)

New Carrier's Control No. 22933820

Old Carrier's Control No

TO EMPLOYING OFFICE: SHOW OLD CARRIER'S CONTROL NUMBER ONLY IF ELECTION IS TO CANCEL ENROLLMENT OR TO CHANGE OPTIONS OR TYPE OF ENROLLMENT IN THE SAME PLAN.

PART A — ALL WHO REGISTER MUST FILL IN THIS PART.

1. NAME (LAST) (FIRST) (MIDDLE INITIAL): Collins Wendy S
2. DATE OF BIRTH (Use numbers): MONTH 03 DAY 22 YEAR 53
3. ARE YOU NOW MARRIED? Yes [1] No [2] ✗
4. YOUR MAILING ADDRESS (NUMBER AND STREET): 1630 Hobart St, N.W
   (CITY) (STATE) (ZIP CODE): Washington D.C. 20009
5. SOCIAL SECURITY ACCOUNT NUMBER: 024-44-5763
6. SEX: MALE [1] FEMALE [2] ✗

IMPORTANT

IT IS ILLEGAL FOR AN EMPLOYEE OR A MEMBER OF HIS FAMILY TO BE COVERED UNDER MORE THAN ONE ENROLLMENT. IF YOU ARE ALREADY COVERED THROUGH THE FAMILY ENROLLMENT OF ANOTHER FEDERAL OR DISTRICT OF COLUMBIA EMPLOYEE OR ANNUITANT YOU MUST REGISTER NOT TO ENROLL OR THE OTHER ENROLLMENT MUST BE CANCELED OR CHANGED TO SELF ONLY. SIMILARLY, IF A FAMILY MEMBER LISTED BY YOU IN PART B IS COVERED THROUGH HIS (OR HER) OWN ENROLLMENT, YOU CANNOT ELECT A FAMILY ENROLLMENT UNLESS THE FAMILY MEMBER CANCELS HIS (OR HER) ENROLLMENT. ALSO SEE BACK OF PAGES 2 AND 3.

PART B — FILL IN THIS PART IF YOU WISH TO ENROLL OR CHANGE YOUR ENROLLMENT IN A HEALTH BENEFITS PLAN.

If enrollment is for Self Only, answer item 1. If enrollment is for Self and Family, also answer item 2.

IF YOU ARE CHANGING YOUR ENROLLMENT ALSO FILL IN PART D.

1. I elect to enroll in a health benefits plan as shown below. I authorize deductions from my salary, compensation, or annuity to cover my share of the cost of the enrollment. (Copy the information requested below from back page of brochure of the plan you select.)

NAME OF PLAN	OPTION (HIGH OR LOW)	ENROLLMENT CODE NUMBER
Blue Cross/Blue Shield Service Benefit Plan	HIGH	1 0 1

2. In space below list all eligible family members without exception: List your wife or husband first, then your unmarried children under age 22, including (a) legally adopted children and (b) stepchildren, foster children, and illegitimate children who live with you in a regular parent-child relationship. Include also any unmarried child over 22 who became disabled before age 22 and who, because of the disability, is incapable of self-support. (Attach a doctor's certificate for a disabled child age 22 or over, if one is not already on file.) **DO NOT LIST PARENTS OR OTHERS WHO ARE NOT ELIGIBLE FAMILY MEMBERS. THEY WILL NOT RECEIVE BENEFITS, EVEN IF THEY ARE DEPENDENT ON YOU AND ARE LISTED.**

NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)	NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)
Wife or Husband	1		6
	2		7
	3		8
	4		9
	5		10

PART C — FILL IN THIS PART IF YOU WISH NOT TO ENROLL OR IF YOU WISH TO CANCEL YOUR ENROLLMENT.

PLACE AN "X" IN ITEM 1 OR 2 WHICHEVER APPLIES.

1. I ELECT NOT TO ENROLL IN A PLAN UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM [ ]
2. I ELECT TO CANCEL MY PRESENT ENROLLMENT UNDER THE CODE NUMBER SHOWN BELOW: [ ]

Present Enrollment Code Number

If you elect to cancel be sure to read "Cancellation of Enrollment" on back of page 3.

PART D — FILL IN THIS PART, AS WELL AS PART B, TO CHANGE YOUR REGISTRATION.

ANSWER ITEMS 1, 2, AND 3 TO SHOW ENROLLMENT CODE BEING CHANGED AND ELIGIBILITY FOR CHANGE.

1. ENROLLMENT CODE NUMBER OF PRESENT PLAN
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PART E — ALL WHO REGISTER MUST FILL IN THIS PART.

Wendy S Collins (YOUR SIGNATURE—DO NOT PRINT) Aug 5, 1978 (DATE)

WARNING.—Any intentional false statement in this application or wilful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both (18 U.S.C. 1001.)

PART F — TO BE COMPLETED BY AGENCY

1. NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYING OFFICE
   U.S. House of Representatives
   Office of Finance, Washington, D.C. 20515
   (SIGNATURE OF AUTHORIZED AGENCY OFFICIAL)
2. DATE RECEIVED IN EMPLOYING OFFICE
3. EFFECTIVE DATE OF ELECTION
4. PAYROLL OFFICE NO. 00004832
5. SF 2811 REPORT NO.

REMARKS — FOR USE ONLY BY AGENCY.

Standard Form No. 2809
U.S. Civil Service Commission

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HEALTH BENEFITS REGISTRATION FORM

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

(Read instructions on back of page 3.)

New Carrier's Control No. 22933820

TO EMPLOYING OFFICE: SHOW OLD CARRIER'S CONTROL NUMBER ONLY IF ELECTION IS TO CANCEL ENROLLMENT OR TO CHANGE OPTIONS OR TYPE OF ENROLLMENT IN THE SAME PLAN.

Old Carrier's Control No.

PART A

ALL WHO REGISTER MUST FILL IN THIS PART.

1. NAME (LAST) (FIRST) (MIDDLE INITIAL): Collins, Wendy S
2. DATE OF BIRTH (Use numbers): MONTH 03 DAY 22 YEAR 53
3. ARE YOU NOW MARRIED? Yes 1 / No [X] 2
4. YOUR MAILING ADDRESS (NUMBER AND STREET): 1630 Hobart St, N.W.
   (CITY) (STATE) (ZIP CODE): Washington D.C. 20009
5. SOCIAL SECURITY ACCOUNT NUMBER: [illegible]
6. SEX: MALE 1 / FEMALE [X] 2

IMPORTANT

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NAME OF PLAN	OPTION (HIGH OR LOW)	ENROLLMENT CODE NUMBER
Blue Cross/Blue Shield Service Benefit Plan	HIGH	1 0 1

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NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)	NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)
Wife or Husband	1		6
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PART C

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Present Enrollment Code Number:

If you elect to cancel be sure to read "Cancellation of Enrollment" on back of page 3.

PART D

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PART E

ALL WHO REGISTER MUST FILL IN THIS PART.

Wendy S Collins (YOUR SIGNATURE- DO NOT PRINT)

Aug 5, 1978 (DATE)

WARNING.—Any intentional false statement in this application or wilful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both (18 U.S.C. 1001.)

PART F

TO BE COMPLETED BY AGENCY

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   U.S. House of Representatives
   Office of Finance, Washington, D.C. 20515

   (SIGNATURE OF AUTHORIZED AGENCY OFFICIAL)
2. DATE RECEIVED IN EMPLOYING OFFICE
3. EFFECTIVE DATE OF ELECTION
4. PAYROLL OFFICE NO. [illegible]
5. SF 2811 REPORT NO.

REMARKS

FOR USE ONLY BY AGENCY.

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HEALTH BENEFITS REGISTRATION FORM

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

(Read instructions on back of page 3.)

New Carrier's Control No. 22933820

Old Carrier's Control No.

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Best image possible.

PART A

ALL WHO REGISTER MUST FILL IN THIS PART.

1. NAME (LAST) (FIRST) (MIDDLE INITIAL): [illegible]
2. DATE OF BIRTH (Use numbers): MONTH / DAY / YEAR: [illegible]
3. ARE YOU NOW MARRIED? Yes [1] No [2] ✓
4. YOUR MAILING ADDRESS (NUMBER AND STREET): [illegible]
(CITY) (STATE) (ZIP CODE): [illegible]
5. SOCIAL SECURITY ACCOUNT NUMBER
6. SEX MALE [1] FEMALE [2] ✓

IMPORTANT

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NAME OF PLAN	OPTION (HIGH OR LOW)	ENROLLMENT CODE NUMBER
[illegible]	[illegible]	[illegible]

2. In space below list all eligible family members without exception: List your wife or husband first, then your unmarried children under age 22, including (a) legally adopted children and (b) stepchildren, foster children, and illegitimate children who live with you in a regular parent-child relationship. Include also any unmarried child over 22 who became disabled before age 22 and who, because of the disability, is incapable of self-support. (Attach a doctor's certificate for a disabled child age 22 or over, if one is not already on file.) **DO NOT LIST PARENTS OR OTHERS WHO ARE NOT ELIGIBLE FAMILY MEMBERS. THEY WILL NOT RECEIVE BENEFITS, EVEN IF THEY ARE DEPENDENT ON YOU AND ARE LISTED.**

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Wife or Husband	1		6
	2		7
	3		8
	4		9
	5		10

PART C

FILL IN THIS PART IF YOU WISH NOT TO ENROLL OR IF YOU WISH TO CANCEL YOUR ENROLLMENT.

PLACE AN "X" IN ITEM 1 OR 2 WHICHEVER APPLIES:

1. I ELECT NOT TO ENROLL IN A PLAN UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.
2. I ELECT TO CANCEL MY PRESENT ENROLLMENT UNDER THE CODE NUMBER SHOWN BELOW:

Present Enrollment Code Number

If you elect to cancel be sure to read "Cancellation of Enrollment" on back of page 3.

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3. DATE OF EVENT WHICH PERMITS CHANGE: MONTH / DAY / YEAR

PART E

ALL WHO REGISTER MUST FILL IN THIS PART.

[illegible signature] (YOUR SIGNATURE - DO NOT PRINT) Aug 5 1975 (DATE)

WARNING.—Any intentional false statement in this application or wilful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both (18 U.S.C. 1001.)

PART F

TO BE COMPLETED BY AGENCY

1. NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYING OFFICE

U.S. House of Representatives
Office of Finance, Washington, D.C. 20515

(SIGNATURE OF AUTHORIZED AGENCY OFFICIAL)

2. DATE RECEIVED IN EMPLOYING OFFICE
3. EFFECTIVE DATE OF ELECTION
4. PAYROLL OFFICE NO. [illegible]
5. SF 2811 REPORT NO.

REMARKS

FOR USE ONLY BY AGENCY.

PAYROLL INFORMATION FORM AND PERSONNEL AFFIDAVIT
PLEASE USE TYPEWRITER OR PRINT IN INK

CODE: Finance Office Use Only

U.S. HOUSE OF REPRESENTATIVES

Name Collins, Wendy Susan (Last—First—Middle) Employing Office U.S. House Select Committee on Assassinations

Social Security No. 024-44-5163 Date of birth 03-22-53 (Month—Day—Year)

ADDRESSES

Mailing address for withholding tax statement:
1630 Hobart St, N.W.
Washington, D.C. 20009

Mailing address for payroll check (Bank, home, office, etc.):
Select Committee on Assassinations
House Annex #2 - RM
WASH, D.C. 20515

FINANCE OFFICE USE ONLY
Bank Code:

Bank Account No. ______
(Do not insert Bank Account Number unless check is to be mailed to a bank)

PREVIOUS FEDERAL CIVILIAN SERVICE

☐ House of Representatives—Office of Select Committee on Assassinations

Separation date of last service July 31, 78

☐ Other Federal Departments (including Senate and Architect)

Agency ______

Separation date of last service ______

☐ Name (if different from present signature) ______

While employed as above I was covered by:

Federal Employees' Health Insurance: ☑ enrolled; ☐ not enrolled; ☐ excluded.

Federal Employees' Life Insurance: ☐ optional; ☐ regular; ☑ waived; ☐ excluded.

ELECTION OF RETIREMENT COVERAGE

Coverage under the provisions of the Civil Service Retirement Act is extended to employees of the House of Representatives on a voluntary basis. Once you have elected this coverage and retirement deductions have been withheld, such deductions cannot be discontinued so long as you are continuously employed under the Act.

Check the appropriate box to the right:

I elect coverage under the provisions of the Civil Service Retirement Act and request that deductions begin at the earliest possible date. (If you have had previous Federal or Military service, please submit dates, Agencies and Military Serial Number on a separate sheet.) YES ☑

I do not wish to elect coverage under the Retirement Act at this time. NO ☐

(Note: Legislative employees are not covered by the Social Security Act.)

Wendy S. Collins
(Signature)

(Over)

16—82058-1

District of Columbia ~~(or State of)~~ ss:

I do solemnly swear (or affirm)—

(1) That ☑ I am a citizen of the United States;

☐ if in the service on the date of enactment of the latest General Government Matters Appropriation Act, and being eligible for citizenship, I had theretofore filed a declaration of intention to become a citizen;

☐ I owe allegiance to the United States;

☐ I am an alien from Poland or the Baltic countries lawfully admitted to the United States for permanent residence;

☐ I am a citizen of the Republic of the Philippines;

☐ I am a national of a country allied with the United States in the current defense effort;

(2) That my acceptance and holding of office or employment with the U.S. House of Representatives does not or (if this affidavit is executed by me prior to my acceptance of such office or employment) will not constitute a violation of the first section of the Act of August 9, 1955 (5 U.S.C. 7311), which reads as follows:

No person shall accept or hold office or employment in the Government of the United States or any agency thereof, including wholly owned Government corporations, who—

(1) advocates the overthrow of our constitutional form of government in the United States;
(2) is a member of an organization that advocates the overthrow of our constitutional form of government in the United States, knowing that such organization so advocates;
(3) participates in any strike or asserts the right to strike against the Government of the United States or such agency; or
(4) is a member of an organization of Government employees that asserts the right to strike against the Government of the United States or such agencies, knowing that such organization asserts such right;

(3) That I ☐ am / ☒ am not receiving a pension, annuity, or retired pay from the United States Government (if so, please furnish source and claim number);

(Name and location of administering agency) (Claim number)

(4) That this Payroll Information Form and Personnel Affidavit is complete, true, and correct;

(5) That I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter; So help me God.

Subscribed and sworn to before me this

Wendy S Collins
(Signature of employee)

31st day of July, 1978

Elizabeth L. Berney
Notary Public.

~~State of~~ District of Columbia

[NOTARY SEAL]

My commission expires 9-15-82

U.S. GOVERNMENT PRINTING OFFICE 16—82058-1

U.S. House of Representatives

OFFICE OF THE CLERK

OFFICE OF FINANCE

IMPORTANT NOTICE TO EMPLOYEE

Newly employed personnel must execute the attached combined PAYROLL INFORMATION FORM and PERSONNEL AFFIDAVIT properly and submit them to the Office of Finance, where a Notary Public is on duty to perform this service without charge. DO NOT SIGN PERSONNEL AFFIDAVIT UNTIL BEFORE A NOTARY.

Currently employed personnel wishing to make changes in their records need only complete the pertinent section of the PAYROLL INFORMATION FORM, indicate their employing office, and affix their signature. Please be certain that information is legible enough for the Finance Office to identify the individual making the change.

DETACH AND RETAIN THIS NOTICE

Salary payments are made by check monthly and mailed to the address designated on the Payroll Information Form. Checks are disbursed from the Office of Finance to normally reach the addressee on the last working day of each month.

For additional information, contact the Office of Finance, 263 Cannon Office Building, Telephone Extension 56515 or 57064.

EMPLOYEE BENEFITS

RETIREMENT: An employee of the House of Representatives is eligible to join the Federal Civil Service Retirement System. Participation is voluntary, and action to elect retirement coverage may be initiated at any time by completing the appropriate section of the Payroll Information Form. Once an election is filed and the normal deduction of 7½ percent of the gross salary commences, the employee cannot discontinue deductions so long as he is continuously employed. (Note: Legislative employees are not covered by the Social Security Act.)

LIFE INSURANCE: An employee is automatically covered under the Federal Employees' Group Life Insurance Act unless he waives or subsequently cancels such coverage by filing the required waiver form with the Office of Finance. The insurance coverage is $10,000; or an amount equal to the gross annual salary, rounded to the next higher thousand dollars (if the salary is not a multiple of a thousand dollars), plus an additional two thousand dollars; whichever is the greater. Additional optional insurance coverage in the amount of $10,000 is also available.

HEALTH BENEFITS: The Federal Employees' Health Benefits Program is available on a voluntary basis with costs partly financed by the Government. Within 31 days after the effective date of appointment, every employee must register to enroll in a plan or not to enroll. Future opportunities to enroll or to change the type of enrollment are shown in the enclosed pamphlet. Also enclosed is the necessary registration form, Standard Form 2809.

U.S. SAVINGS BONDS: Monthly deductions for bonds in regular bond denominations may be authorized. Authorization cards are available in the Finance Office.

WORK INJURY BENEFITS: An employee injured or incurring disease as a result of performance of duty is entitled to medical care and monetary benefits under the provisions of the Federal Employees' Compensation Act. In instances where such injury or disease is fatal, the employee's family is entitled to monetary benefits. The Compensation Act is administered by the Bureau of Employees' Compensation, U.S. Department of Labor. Forms for filing notices of injury and claims for compensation are available in the Office of Finance or from any Postmaster.

UNEMPLOYMENT COMPENSATION: An employee may under certain circumstances be entitled to unemployment compensation if discharged or otherwise separated from his employment. The compensation is usually payable by the State (including the District of Columbia) in which the employee had his last service. However, a claim for benefits may be filed in the local office nearest the employee's residence. If an employee is discharged for misconduct, quits voluntarily without good cause, or refuses a suitable job without good cause, then there is a period of disqualification which varies from State to State. The amount of payments and period of time payable also varies from State to State.

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M E M O R A N D U M

TO: Thomas Howarth, Budget Officer
Elizabeth Berning, Chief Clerk

FROM: I. Charles Mathews, Special Counsel

DATE: December 19, 1977

RE: Ms. Wendy Collins

Please be advised that Ms. Wendy Collins has accepted the position of Senior Attorney Researcher with the Select Committee on Assassinations. Her effective starting date will be December 29, 1977 and her starting salary will be $18,000.00.

Your full cooperation will be appreciated in familiarizing her with staff procedures and welcoming her aboard.

ICM:jl

M E M O R A N D U M

TO: ALL STAFF

RE: Payroll Certification

The Regulations and Accounting Procedures for Allowances and Expenses of Committees, Members and Employees of the U.S. House of Representatives require that, among other things, the Committee's monthly payroll certification include the relationship, if any, of each employee to any current Member of Congress. This certification is signed monthly by our Chairman.

The following are the relationships to be included in the certification:

father	nephew	brother-in-law
mother	niece	sister-in-law
son	husband	stepfather
daughter	wife	stepmother
brother	father-in-law	stepbrother
sister	mother-in-law	stepsister
uncle	son-in-law	half-brother
aunt	daughter-in-law	half-sister
first cousin		

Please complete the appropriate portion below, sign and date this form, which will then become a part of your permanent personnel file. If this status changes, you must notify the Committee's Budget Office immediately of the change.

☑ I am not related to any current (95th Congress) Member of Congress.

☐ I am related to a current (95th Congress) Member of Congress. (Please specify.) ______________________

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Wendy S Collins
Signature of Employee

29 Dec 77
Date